



HEALTH PROFESSIONS
EDUCATION FOUNDATION

Giving Golden Opportunities



Health Professions Education Program

Scholarship & Loan Repayment Application

This project is made possible by a grant from the Vitamin Cases
Consumer Settlement Fund.

Giving Golden Opportunities by:

*Increasing the supply of
health professionals practicing in
underserved areas*

*Improving access to healthcare in
rural and urban areas of California*

*Helping students to pursue a
career in the health professions*

*Awarding health professionals who
are dedicated to practicing in
underserved communities*

Application Instructions

APPLICANTS MAY APPLY FOR ONLY ONE AWARD USING THIS APPLICATION.

The Health Professions Education Program offers two types of awards: the **Health Professions Education Scholarship** and the **Health Professions Education Loan Repayment**. The purpose of these awards is to increase the number of health professionals practicing in the medically underserved areas of California. Applications for the Health Professions Education Program are accepted annually in March.

Any monies awarded under this program are intended to pay or repay tuition, required fees, books, supplies, and educational equipment costs related to the applicants health professional education. All awards are subject to the availability of funding.

SELECTION CRITERIA

Selection for Health Professions Education awards is based solely on information contained in the application and supporting documentation. Selection for awards is based on the following criteria:

Work Experience - experience providing direct patient care in a medically underserved area (MUA).

Financial Need - actual or potential difficulty in completing education in the absence of an award.

Career Goals - professional goals for the next five to ten years.

Community Service - documented volunteer service and/or activities, particularly in a MUA.

Community Background - family structure and community where you grew up; for example, rural, inner city/urban, suburban, or MUA.

Academic Performance - prior and current academic performance; potential for future academic success.

Priority will be given to:

Individuals whose community background and commitment indicates the likelihood of long-term employment in a medically underserved area even after the service obligation has ended.

Awards are made on a competitive basis. Each part of the application must be completed. All supporting documentation must be submitted. Only complete applications will be evaluated. The Foundation will not notify individuals if their application is incomplete.

SCHOLARSHIPS

Students may receive up to **\$10,000** for the **Health Professions Education Scholarship**. Scholarships are funded for one academic year, usually 2 semesters or 3 quarters.

Scholarship Eligibility

Scholarships are available to students who are enrolled or accepted in a Health Professions program. Awardees must sign a contract with the Office of Statewide Health Planning and Development and agree to the following terms:

Be enrolled or accepted to one of the following health professional education programs:

- Dentistry • Nurse Practitioner • Physician Assistant
- Dental Hygiene • Certified Nurse Midwifery

Be a U.S. citizen or permanent resident and a California resident.

Complete a 2-year service obligation to practice your profession in a medically underserved area of California providing direct patient care.

Be a full-time or part-time student (no less than 6.0 units) in a California accredited school.

Maintain a minimum cumulative GPA of 2.0 each year scholarship funds are sought.

SCHOLARSHIP APPLICATION

Submit the following:

1. Official Transcript(s) related to your health professional education

If you are a student in your first year of the health professional program and your transcripts do not reflect your health professional education, submit your most current transcript.

The transcript must be marked official by the school and delivered to the Foundation in a sealed envelope. The Foundation will not accept unofficial transcripts, copies or print outs of transcripts, or transcripts in a broken envelope.

2. Personal Statements (Part D of the Application)

Attach your personal statements to the application. Your statements must be typed. Statements must provide a comprehensive response to each question. Please limit all Personal Statements to not more than 6 pages. Restate and number each question along with your answer.

3. Two letters of recommendation

Letters of recommendation must be current or dated within the last six months of the application deadline. The letters must be on letterhead or include the author's title, name of employer, mailing address, and phone number. It is recommended that at least one letter be from a faculty member. Letters of recommendation that confirm community service are also encouraged.

4. Graduation Date Verification Form

This form must be signed by the program director or faculty members authorized to sign on the director's behalf. The Graduation Date Verification Form is enclosed as part of the scholarship application. Applicants can also download this form from the Foundation's web site at www.healthprofessions.ca.gov.

5. Student Aid Report (SAR)

Students must submit the final 2006-2007 SAR. The SAR must indicate the student's expected family contribution (EFC). The FAFSA is available from all college financial aid offices and is also available on the Internet at www.ed.gov/offices/OPE/express.html.

Or

2005 Federal tax return with all W-2s.

Applicants who do not apply for financial aid must submit complete copies of their 2005 Federal tax return with all W-2s. Do not submit State tax returns. State tax returns will not be accepted in lieu of the Federal tax return.

Application Instructions (cont)

LOAN REPAYMENT AWARDS

The **Health Professions Loan Repayment Program** repays up to **\$20,000** in educational debt that was incurred while attending a health professional program. In return for the loan repayment, the awardee must agree to practice direct patient care in a medically underserved area for a minimum of 2 years.

Loan Repayment Eligibility

Loan repayment awards are available to licensed health professionals, who are currently practicing in a MUA. If you have any questions about whether your facility qualifies as a MUA, please contact HPEF at (800) 773-1669. Awardees must sign a contract with the Office of Statewide Health Planning and Development and agree to the following terms:

Be a graduate of one of the following health professional education programs:

- Dentistry
- Nurse Practitioner
- Physician Assistant
- Dental Hygiene
- Certified Nurse Midwifery

Be a U.S. citizen or permanent resident and a California resident.

Complete a 2-year service obligation to practice your profession in a medically underserved area of California providing direct patient care. While completing the service obligation, **work full-time or work a minimum of 32 hours per 5 day period** or work week.

Be a currently licensed health professional.

SUBMIT THE FOLLOWING:

1. Official Transcript(s) with your health professional degree posted

The transcript must be marked official by the school and submitted to the Foundation in a sealed envelope. If the school does not release official transcripts to the student, the transcript may be sent directly from the school to the Foundation. The Foundation will not accept unofficial transcripts, copies or print outs of transcripts, or transcripts in a broken envelope.

Your health professional degree must be posted on the transcript unless you are a student in the final year in a course of study leading to a health professional degree. If you are in the final year of the program, submit the most current transcript(s) that illustrate your health professional education to date.

2. Personal Statements (Part D of the Application)

Attach your personal statements to the application. Your statements must be typed. Statements must provide a comprehensive response to each question. Please limit all Personal Statements to not more than 6 pages. Restate and number each question along with your answer.

3. Two letters of recommendation

Letters must be current or dated within the last six months of the application deadline. The letters must be on letterhead or include the author's title, name of employer, mailing address, and phone number. Letters of recommendation that confirm community service are also encouraged.

4. Employment Verification Form

This form must be signed by an official in your personnel department. The Employment Verification Form is enclosed as part of the application. Applicants can also download this form from the Foundation's Web site at www.healthprofessions.ca.gov.

5. 2005 Federal tax return with all W-2s

Do not submit State tax returns. State tax returns will not be accepted in lieu of the Federal tax return.

6. Educational Debt Reporting Form

Submit the attached educational debt reporting form and copies of your most recent lender statements with your name, the name of lender, balance owing, account number, and monthly payments. All information must be filled in or the application will be considered incomplete.

INELIGIBILITY FOR THE HEALTH PROFESSIONS EDUCATION AWARDS

Applicants who owe a service obligation to practice direct patient care to another entity entered into before filing an application with the Foundation are ineligible to receive a scholarship. Previous obligations must be completed before applying. Awardees who breach their contract with the Office of Statewide Health Planning and Development will not be allowed to reapply for additional awards.

APPLICATION SUBMISSION

Applications must be postmarked by the deadline. In order to be reviewed, each part of the application must be completed. All supporting documentation must be submitted. The Foundation will not notify applicants if their application is received incomplete. Applicants are urged to contact the Foundation at (800) 773-1669 prior to the final filing date to verify if their application was received complete. Do not bind or submit applications in a loose-leaf binder.

NOTIFICATION OF AWARDS

The Foundation will notify applicants of their application results within eight weeks of the final filing date.

APPLICATION POSTMARK DEADLINE: MARCH 24, 2006

Submit applications to:

**Health Professions Education Foundation
Health Professions Education Program
818 K Street, Suite 210
Sacramento, CA 95814
(800) 773-1669 or (916) 324-6500**

Application

Do you owe an existing service obligation to another entity? ☐ Yes ☐ No

(If yes, previous obligations must be completed before applying)

Please indicate which award you are applying for:

- ☐ Health Professions Education Scholarship: \$10,000
☐ Health Professions Education Loan Repayment: \$20,000

Please enter the scholarship or loan repayment amount you are requesting: _____

Please refer to the application instructions when completing the application. Complete each part of the application form. Make sure all supporting documents are submitted with your application. Applications and all supporting documents must be postmarked by the due date. Late applications will not be evaluated.

PART A – PERSONAL INFORMATION

Applicants may apply for only one award using this application.

(Please type or print your answers in the space provided)

Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

County: _____

Permanent Address: _____

City: _____ State: _____ Zip: _____

County: _____

Home Phone: _____ Work Phone: _____

Social Security # _____ - _____ - _____ CA Drivers License # _____

Date of birth: ____/____/____ Age: _____ Gender: ☐ Male ☐ Female

Marital Status: ☐ Unmarried ☐ Married

Number of dependents other than self and spouse: _____

(As declared on tax returns or student aid report)

Are you a previous awardee of the Foundation? ☐ Yes ☐ No

If yes, please enter the contract #: _____

Are you currently employed as a licensed health professional?

☐ Yes ☐ No

If yes, provide license # _____ Expiration date: ____/____/____

Are you the first in your family to attend college? ☐ Yes ☐ No

Which best describes your ethnic background:

☐ Asian American ☐ Pacific Islander ☐ African American

☐ Caucasian ☐ Native American ☐ Hispanic/Latino

☐ Other (Please specify) _____

If Native American, please specify tribal affiliation and submit verification: _____

List any languages you can speak, read, and write in addition to English. Check all that apply.

1 _____ ☐ Speak ☐ Read ☐ Write

2 _____ ☐ Speak ☐ Read ☐ Write

Are you a citizen or permanent resident of the U.S.? ☐ Yes ☐ No
(If no, do not continue. You must be a citizen or permanent resident to apply)

Are you a California resident? ☐ Yes ☐ No

PART B – WORK EXPERIENCE

Please list all paid and/or unpaid work experience you may have had.

List most recent employer first. Attach additional work history on page 5.

(Maximum of 5 employers)

Employer's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

County: _____

Your Supervisor's Name: _____ Office Phone: _____

Your Position/title: _____ Monthly Salary: _____

☐ Paid worker **OR** ☐ Non paid ☐ Full-time **OR** ☐ Part-time

Employment Start Date: ____/____/____ Employment End Date: ____/____/____

Average hours worked (please choose only one):

____/day ____/week ____/month

Brief description of your job duties: _____

FOR OFFICIAL USE ONLY

Recd:	Compl / Inc:	Omitted: App Pgs	GDV	EVF	SAR	TAX	LoR	Oth
App Inquiry: (- -) (- -)	HPEF Contact: for:							
Input By:	MUA: Yes / No	CT#:						
Reviewed By:	Comments:							

Application

Please refer to the application instructions before you begin.

Health Professions Education Scholarship: \$10,000
Health Professions Education Loan Repayment: \$20,000

PART C – COMMUNITY BACKGROUND

For each age category below, list the city, county, and state you grew up in. Check all items that best describe your socioeconomic background.

Age Category Birth-10 years Rural ☐ Inner City/Urban ☐ Suburban ☐ | Poor ☐ Middle-class ☐ Upperclass ☐
City: _____ County: _____ State: _____
Country: _____

Age Category 11-20 years Rural ☐ Inner City/Urban ☐ Suburban ☐ | Poor ☐ Middle-class ☐ Upperclass ☐
City: _____ County: _____ State: _____
Country: _____

Age Category 21-30 years Rural ☐ Inner City/Urban ☐ Suburban ☐ | Poor ☐ Middle-class ☐ Upperclass ☐
City: _____ County: _____ State: _____
Country: _____

Age Category 31-40 years Rural ☐ Inner City/Urban ☐ Suburban ☐ | Poor ☐ Middle-class ☐ Upperclass ☐
City: _____ County: _____ State: _____
Country: _____

Age Category 41+ years Rural ☐ Inner City/Urban ☐ Suburban ☐ | Poor ☐ Middle-class ☐ Upperclass ☐
City: _____ County: _____ State: _____
Country: _____

PART D – PERSONAL STATEMENTS

Attach your personal statements to the application. Your statements must be typed. Restate and number each question along with your answer.

***Scholarship applicants must answer questions 1-6.**

***Loan repayment applicants must answer questions 1-5.**

1. What kind of work do you think you'll be doing in five years?
2. What is your vision of your professional future in ten years?
3. Describe any community service, volunteer activities, or club memberships within the past two years (Please attach any letters of recommendation you may have. Do not include experience for which you received academic credit).
4. Briefly describe your family background including: your father's and mother's occupation, annual income, marital status, and number of dependents including yourself.
5. Describe how your background is relevant to your interest in pursuing a health career. Do you see your background as an advantage, disadvantage or both?

Scholarship Applicants only:

6. What kind of work would you like to do immediately after graduation?

PART E – QUESTIONNAIRE

Where did you hear about the Health Professions Education Program?

(Check all that apply)

- ☐ School ☐ Work (employer or co-worker) ☐ Friend/Acquaintance
☐ Foundation Web site ☐ Other Web site ☐ Advertisement ☐ TV ☐ Radio
☐ Newspaper or publication (please specify) _____
☐ Organization or Affiliation (please specify) _____
☐ Other source (please specify) _____

Where did you receive the Health Professions Education Program application form? (Check only one.)

- ☐ Financial Aid Office ☐ Program Director/Instructor ☐ Foundation office ☐
Foundation Web site ☐ Other Web site ☐ Work (employer/co-worker)
☐ Friend/Acquaintance
☐ Other please specify _____

PART F – APPLICATION CERTIFICATION

I certify that all information in this application is true and accurate to the best of my knowledge. I authorize the Health Professions Education Foundation to verify any information submitted as part of this application. I understand that falsification of information contained in this application will disqualify my application and the respective licensing Board will be notified.

I understand that if falsification is discovered after I have been awarded, I will be required to repay all funds awarded, plus interest and administrative fees.

I understand that once submitted, my application and supporting documents become the rights of the Health Professions Education Foundation. I also understand that my personal statements become the property of the Foundation and may be used, including but not limited to, advertising/marketing, program reports, newsletters, and other publications.

Printed name: (last name, first name, middle initial)

Applicant's Signature: _____ Date: _____

POSTMARK DEADLINE MARCH 24, 2006

SUBMIT APPLICATIONS TO:

Health Professions Education Foundation
Health Professions Education Program
818 K Street, Suite 210
Sacramento, CA 95814

SCHOLARSHIP CHECKLIST

- ☐ 1. Official Transcript(s) related to your health professions education
☐ 2. Personal Statements
☐ 3. Two (2) Letters of Recommendation
☐ 4. Graduation Date Verification Form
☐ 5. 2006-2007 Student Aid Report (SAR)
or
2005 Federal tax return and all W-2s

LOAN REPAYMENT CHECKLIST

- ☐ 1. Official Transcript(s) with health professions degree posted
☐ 2. Personal Statements
☐ 3. Two (2) Letters of Recommendation
☐ 4. Employment Verification Form
☐ 5. 2005 Federal Tax Return and all W-2s
☐ 6. Educational Debt Reporting Form and Lender Statements

GRADUATION DATE VERIFICATION FORM

(For Scholarship Applicants Only)

***Must be completed by the Program Director or the director's designee.**

The student named below is applying for a scholarship from the Health Professions Education Foundation. This form is required for the application to be considered. Please return this form to the Foundation with original signature.

Applicant's Name: _____

Health Professional Program: ☐ Dentistry ☐ Dental Hygiene ☐ Nurse Practitioner
☐ Physician Assistant ☐ Certified Nurse Midwifery

School: _____

Address: _____

City: _____ County: _____ State: _____ Zip _____

Year Entered: _____ Expected Graduation Date: _____
Month/Year Month/Year

Enrollment Status: F/T ☐ P/T ☐ # of units currently enrolled _____

Please comment on the student's performance and potential for academic success.

This form was completed by:

Name: (Please Print) _____ Title: _____

Signature: _____ Date: _____

Phone Number: (____) _____

Please check one:

- ☐ I certify that I am the Program Director.
☐ I certify that I am authorized to sign this document on behalf of the Program Director.

EMPLOYMENT VERIFICATION FORM

(For Loan Repayment Applicants Only)

ATTENTION! The completed form must bear an original ink signature.

Photocopies and faxed copies of the completed form are not acceptable.

FORM TO BE COMPLETED BY AN OFFICIAL IN THE PERSONNEL OR HUMAN RESOURCES DEPARTMENT

Employee's Name: _____

Date of Hire: _____ Position Title: _____ Monthly Salary: _____

Employment Status: F/T ☐ P/T ☐ _____

Average weekly hours worked: _____

Employer: _____ Employee's Supervisor: _____

Title: _____ Telephone Number: _____

Employer's Address: _____

City: _____ State: _____ Zip Code: _____

County: _____

Additional Comments:

This form was completed by:

Name: (Please Print) _____ Title: _____

Signature: _____ Date: _____

Phone Number: () _____

Additional Work History

Please print legibly or type. Please list all paid and/or unpaid work experience you have had with a maximum of four employers.
(resumes will not be used in place of history page.)

Employer's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

County: _____

Your Supervisor's Name: _____ Office Phone: _____

Your Position/title: _____ Monthly Salary: _____

☐ Full-time OR ☐ Part-time

Employment Start Date: __/__/__ Employment End Date: __/__/__

Average hours worked (please choose only one): ____/day ____/week ____/month

Brief description of your job duties: _____

Employer's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

County: _____

Your Supervisor's Name: _____ Office Phone: _____

Your Position/title: _____ Monthly Salary: _____

☐ Full-time OR ☐ Part-time

Employment Start Date: __/__/__ Employment End Date: __/__/__

Average hours worked (please choose only one): ____/day ____/week ____/month

Brief description of your job duties: _____

Employer's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

County: _____

Your Supervisor's Name: _____ Office Phone: _____

Your Position/title: _____ Monthly Salary: _____

☐ Full-time OR ☐ Part-time

Employment Start Date: __/__/__ Employment End Date: __/__/__

Average hours worked (please choose only one): ____/day ____/week ____/month

Brief description of your job duties: _____

Employer's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

County: _____

Your Supervisor's Name: _____ Office Phone: _____

Your Position/title: _____ Monthly Salary: _____

☐ Full-time OR ☐ Part-time

Employment Start Date: __/__/__ Employment End Date: __/__/__

Average hours worked (please choose only one): ____/day ____/week ____/month

Brief description of your job duties: _____

Educational Debt Reporting Form

(For Loan Repayment Applicants Only)

- List source and amounts of outstanding educational loans used to finance your education below.
- You must submit evidence of the educational debts listed below (i.e. current statements for referenced accounts which includes the current balance, account number, your name, and address to which payment is submitted.).

All spaces must be completed. If payments are deferred an amount must be entered into the monthly payment space.
If any information is missing the application will be considered incomplete.

LOAN 1

School Attended: _____

Loan Period (Start Date): _____ (End Date): _____

Loan Program: _____

Loan ID#: _____

Lending Institution: _____

Lender's Address: _____

City: _____ State: _____ Zip: _____

Outstanding Balance: \$ _____ Monthly Payment: \$ _____

LOAN 2

School Attended: _____

Loan Period (Start Date): _____ (End Date): _____

Loan Program: _____

Loan ID#: _____

Lending Institution: _____

Lender's Address: _____

City: _____ State: _____ Zip: _____

Outstanding Balance: \$ _____ Monthly Payment: \$ _____

LOAN 3

School Attended: _____

Loan Period (Start Date): _____ (End Date): _____

Loan Program: _____

Loan ID#: _____

Lending Institution: _____

Lender's Address: _____

City: _____ State: _____ Zip: _____

Outstanding Balance: \$ _____ Monthly Payment: \$ _____

LOAN 4

School Attended: _____

Loan Period (Start Date): _____ (End Date): _____

Loan Program: _____

Loan ID#: _____

Lending Institution: _____

Lender's Address: _____

City: _____ State: _____ Zip: _____

Outstanding Balance: \$ _____ Monthly Payment: \$ _____

LOAN 5

School Attended: _____

Loan Period (Start Date): _____ (End Date): _____

Loan Program: _____

Loan ID#: _____

Lending Institution: _____

Lender's Address: _____

City: _____ State: _____ Zip: _____

Outstanding Balance: \$ _____ Monthly Payment: \$ _____

LOAN 6

School Attended: _____

Loan Period (Start Date): _____ (End Date): _____

Loan Program: _____

Loan ID#: _____

Lending Institution: _____

Lender's Address: _____

City: _____ State: _____ Zip: _____

Outstanding Balance: \$ _____ Monthly Payment: \$ _____



HEALTH PROFESSIONS EDUCATION FOUNDATION

Giving Golden Opportunities

818 K Street, Suite 210
Sacramento, CA 95814
www.healthprofessions.ca.gov
(800) 773-1669

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